Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 1, 2017

Mr. Dane Rank, Manager
Thompson Residential Home
80 Maple Street
Brattleboro, VT 05301

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on February 8, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0156 | A. BUILDING: _____ B. WING _____ | R 02/08/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THOMPSON RESIDENTIAL HOME | 80 MAPLE STREET BRATTLEBORO, VT 05301 |

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| {R100} | Initial Comments:<br><br>An unannounced on-site follow up survey was conducted by the Division of Licensing and Protection on 2/7 and 2/8/17. This was a follow up for the 7/13/16 citations. The facility failed to correct three of the citations, and a new citation was identified related to the follow up survey. Findings include: | {R100} | | |
| R161 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure that the manager of the house was responsible for handling of all medications according to the home's policies and that designated staff are fully trained in the policies and procedures. Findings include:<br><br>During an observation of preparation of insulin for Resident #3, on 2/7/17 at 11:46 AM, the Resident Care Assistant (RCA) prepared 12 Units of Humalog insulin. When asked what the insulin was and the dose, s/he responded that Resident #3 was to receive 11 Units of Humalog insulin per the sliding scale ordered by the physician. Upon examination of the syringe with the RCA and the Registered Nurse (RN), it was confirmed that 11 Units of Humalog was what was ordered and 12 Units had been drawn into the syringe by the | R161 | Staff instructed on use of insulin syringes Clarified and demonstrated ability to draw up insulin and administer per protocols.<br><br>Use of vial insulin discontinued in facility. Pens ordered for all residents and instituted with dial-a-dose delivery.<br><br>Education and competency of all medication staff practiced and demonstrated.<br><br>Insulin administration training will be compled upon hire, and reviewed annually with all staff during review.<br><br>Staff education will be audited at least yearly for insulin training with results reported to the Manager.<br><br>POC for 161-188 ampth 2.28.17 BB/BP | 2/8/17<br><br>2/11/17 and ongoing<br><br>2/11/17<br><br>2/11/17 and ongoing<br><br>2/11/17 and ongoing |

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| R161 | Continued From page 1<br><br>RCA. While the RN was reviewing the syringe and the amount of insulin, the RCA stated that s/he gets confused by the lines on the syringe. The RN adjusted the dose of insulin and the RCA administered. Per interview with the RN at this time, s/he stated that the RCA has been administering medications since October and that s/he had been trained by the Director of Nurses (DNS) from the Nursing Home portion of the facility. At 2:02 PM, the DNS stated that s/he had done the training, but was unable to locate the documentation surrounding the training. Request of documentation training for three (3) other medication trained staff and of the four (4) reviewed, only one (1) had evidence of training. At 2:28 PM, the RN and the DNS confirmed that there is no evidence to ensure that the training was provided. Per interview with the house manager on 2/8/17 at 9:48 AM, s/he stated that s/he handles the payroll and business end of the Residential Care Home and the RN handles the day to day management of resident care and staff training.<br><br>See also R168. | R161 | | |
| {R165} SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:<br><br>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:<br>i. Teaching designated staff proper techniques | {R165} | All MAT staff have been instructed, monitored, and evaluated for proficiency in medication administration and process.<br><br>Staff will be reviewed annually and as needed for copentency by an RN. Resident condition will be passed on in report. Any concerns that need an RN will be addressed by RN on call. Changes in condition will be communicated to the RN. | 2/11/17<br><br>2/11/17 and ongoing |

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| {R165} | Continued From page 2<br>for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;<br>ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;<br>iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure that teaching for three (3) of four (4) sampled staff that are designated to administer medications was completed per State regulations. Findings include:<br><br>Per interview with the Registered Nurse (RN) on 2/7/17 at 11:48 AM, s/he stated that the medication administration training for the Resident Care Assistants was provided by the Director of Nurses (DNS) from the Nursing Home portion of the facility. At 2:02 PM, the DNS stated that s/he had done the training with some of the staff and the RN has assisted with training. Upon request for documentation to support the training for the selected sample of four (4), the DNS and the RN were unable to locate the documentation surrounding the training. Request of documentation training for three (3) other medication trained staff and of the four (4) reviewed, only one (1) had evidence of training. At 2:28 PM, the RN and the DNS confirmed that there is no evidence to ensure that the training was provided. | {R165} | Staff training will be monitored by audit at least yearly, and completed as needed and reviewed yearly in annual review. Reports of the audit will be given to the Manager. | 2/20/17 and ongoing |

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| {R168} SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:<br><br>(6) Insulin. Staff other than a nurse may administer insulin injections only when:<br><br>i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and<br><br>ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and<br><br>iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to insure that staff other than a nurse, that administers insulin, has received additional training in administration of insulin. Findings include:<br><br>During an observation of preparation of insulin for Resident #3, on 2/7/17 at 11:46 AM, the Resident Care Assistant (RCA) prepared 12 Units of Humalog insulin. When asked what the insulin | {R168} | All residential care facility MAT staff were instructed, monitored, and evaluated by the RN in the areas of Diabetic education, blood sugar testing, and insulin administration.<br><br>All insulin will be administered via pen injections.<br><br>All residential care facility MAT staff will be reviewed by the RN annually and upon hire. These reviews will be done by the Manager and included in the employee performance evaluations.<br><br>Records of inservicing will be maintained by the Residential Care Manager or RN Designee.<br><br>Records of inservicing will be audited at least yearly with results reported to the Manager. | 2/11/17<br><br>2/11/17<br><br>2/11/17 and ongoing<br><br>2/11/17 and ongoing<br><br>2/11/16 |

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| {R168} | Continued From page 4<br>was and the dose, s/he responded that Resident #3 was to receive 11 Units of Humalog insulin per the sliding scale ordered by the physician. Upon examination of the syringe with the RCA and the Registered Nurse (RN), it was confirmed that 11 Units of Humalog was what was ordered and 12 Units had been drawn into the syringe by the RCA. While the RN was reviewing the syringe and the amount of insulin, the RCA stated that s/he gets confused by the lines on the syringe. The RN adjusted the dose of insulin and the RCA administered. Per interview with the RN at this time, s/he stated that the RCA has been administering medications since October and that s/he had been trained by the Director of Nurses . (DNS) from the Nursing Home portion of the facility. At 2:02 PM, the DNS stated that s/he had done the training, but was unable to locate the documentation surrounding the training. Request of documentation training for three (3) other medication trained staff and of the four (4) reviewed, only one (1) had evidence of training. At 2:28 PM, the RN and the DNS confirmed that there is no evidence to ensure that the training was provided. The DNS also stated at this time that there is no evidence of additional training for administration of Insulin. | {R168} | | |
| {R188} SS=B | V. RESIDENT CARE AND HOME SERVICES<br><br>5.12.b.(2)<br><br>A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of | {R188} | Residents 1 and 2 instructions ID'd and placed on face sheet.<br><br>All residents' charts were reviewed for instructions in case of a resident's death. Found one additional and noted in chart.<br><br>Resident charts will be reviewed at least quarterly for completeness of face sheet information by RN or designee and | 2/7/17<br><br>2/9/17<br><br>2/8/17 and ongoing |

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| {R188} | Continued From page 5<br>resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to have information for 2 of 5 residents, Resident # 1 and 2, regarding instructions in the case of a resident's death. Findings include:<br><br>During record review, Resident #1 and Resident #2 did not have instructions in case of death listed in their medical record and per interview with the, registered nurse, s/he did not have any information for funeral homes or any other instructions in the event of death for Resident #1 and Resident #2. Confirmation was made at the time of discovery on 2/7/17 at 1:30 PM. | {R188} | reported to Manager quarterly. | 2/11/17 and ongoing |